		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042689

Facility Name: SunBridge Care & Rehab - Edwardsville

Address: 401 St. Mary Drive (Number) Edwardsville (City) 62025 (Zip Code)

County: Madison

Telephone Number: (618) 692-1330 **Fax #** (618) 692-9478

IDPA ID Number: 850370802-023

Date of Initial License for Current Owners: 6/1/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sylvia Moreno **Telephone Number:** (505) 468-4984

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 3/28/01 (Date)
(Type or Print Name) Dean Kiklis
(Title) Vice President of Reimbursement

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds: No Bed Changes

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,007	3,629	4,061	37,697	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,007	3,629	4,061	37,697	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.07%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/1/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/1/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 2,776

Medicare Intermediary TrailBlazer Healthcare Enterprises, LLP

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	145,846	14,695	465	161,006	40,880	201,886	2,834	204,720			1
2	Food Purchase		147,699		147,699		147,699	(70)	147,629			2
3	Housekeeping		487	237,418	237,905		237,905		237,905			3
4	Laundry	474	9,768	64,735	74,977	(233)	74,744		74,744			4
5	Heat and Other Utilities							1,094	1,094			5
6	Maintenance	24,632	5,135	45,983	75,750	6,916	82,666	(5,098)	77,568			6
7	Other (specify):* Please See Attached											7
8	**TOTAL General Services**	170,952	177,784	348,601	697,337	47,563	744,900	(1,240)	743,660			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	1,270,355	159,684	51,904	1,481,943	355,952	1,837,895		1,837,895			10
10a	Therapy		77,256	281,714	358,970		358,970		358,970			10a
11	Activities	32,439	4,516		36,955	8,989	45,944		45,944			11
12	Social Services	42,473		4,755	47,228	11,926	59,154		59,154			12
13	Nurse Aide Training											13
14	Program Transportation							21	21			14
15	Other (specify):* Please See Attached											15
16	**TOTAL Health Care and Programs**	1,345,267	241,456	353,973	1,940,696	376,867	2,317,563	21	2,317,584			16
	C. General Administration											
17	Administrative	60,493		174,562	235,055	16,324	251,379	(73,035)	178,344			17
18	Directors Fees											18
19	Professional Services			30,954	30,954		30,954	7,056	38,010			19
20	Dues, Fees, Subscriptions & Promotions			7,355	7,355		7,355	14,989	22,344			20
21	Clerical & General Office Expenses	112,129	13,164	44,056	169,349	32,785	202,134	84,490	286,624			21
22	Employee Benefits & Payroll Taxes			496,321	496,321	(474,200)	22,121	(11,638)	10,483			22
23	Inservice Training & Education			575	575		575		575			23
24	Travel and Seminar			12,355	12,355		12,355	6,816	19,171			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,606	68,606		68,606	(62,956)	5,650			26
27	Other (specify):* Please See Attached			(8,282)	(8,282)		(8,282)	8,067	(215)			27
28	**TOTAL General Administration**	172,622	13,164	826,502	1,012,288	(425,091)	587,197	(26,211)	560,986			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,688,841	432,404	1,529,076	3,650,321	(661)	3,649,660	(27,430)	3,622,230			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville #0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,785	29,785		29,785	(108)	29,677			30
31	Amortization of Pre-Op. & Org.			33,261	33,261		33,261	10,383	43,644			31
32	Interest			(17,355)	(17,355)		(17,355)	28,620	11,265			32
33	Real Estate Taxes			59,561	59,561		59,561	7,336	66,897			33
34	Rent-Facility & Grounds			226,172	226,172		226,172	2,651	228,823			34
35	Rent-Equipment & Vehicles			29,934	29,934	661	30,595	5,871	36,466			35
36	Other (specify):* Please See Attached			222	222		222	12,248	12,470			36
37	**TOTAL Ownership**			361,580	361,580	661	362,241	67,001	429,242			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,720	74,720		74,720		74,720			42
43	Other (specify):* Please See Attache		2,763	8,708	11,471		11,471		11,471			43
44	**TOTAL Special Cost Centers**		2,763	83,428	86,191		86,191		86,191			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,688,841	435,167	1,974,084	4,098,092		4,098,092	39,570	4,137,662			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	471	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	2		13
14	Non-Care Related Interest	(286)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	15,141	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	17,478	27		24
25	Fund Raising, Advertising and Promotional	(556)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(146,735)	29		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (114,557)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	154,242	SCH VII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 154,242		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 39,685		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SunBridge Care & Rehab - Edwardsville

ID# 0042689

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Employee Meals	$ 0		1
2	Rental Income	0		2
3	Personal Laundry Income	0		3
4	Rebates & Refunds	0		4
5	Sales Tax on food	0		5
6	Interest Income	0		6
7	Penalties and Late Fees	0		7
8	Contributions	0		8
9	Legal Services (Collection Fees)	0		9
10	Bad Debt Expense	0		10
11	Public Relations	0		11
12	Vending Machine Revenue	2,363	1	12
13	Adjust Physical Therapy cost to actual	0	10a	13
14	Management Fee Exp (Ic00)	(77,478)	17	14
15	Chamber of Commerce	(560)	20	15
16	Regional Public Relations	0	20	16
17	Royalty Fees (IC00)	0	20	17
18	Other Non-Oper Inc	0	21	18
19	Regional Marketing Director	0	21	19
20	Cable Tv	(1,841)	21	20
21	Discounts & Rebates	51	21	21
22	Franchise\Intangible T	0	21	22
23	RE Tax Accrual	7,336	33	23
24	Resident Expenses	(5,256)	27	24
25	Depreciation Expense - Equipment	81	30	25
26	Amortization - Leasehold Expense	(189)	30	26
27	Depr Exp Minor Durable Equipment	0	30	27
28	Barber/Beauty Inc	0	40	28
29	Patient Personal Services	0	21	29
30	Pat Personal Svcs Inc	2,102	21	30
31	Incontinency Income	0	10	31
32	Equip Rental Income	0	35	32
33	Community Awareness	(3,599)	27	33
34	Special Events	0	20	34
35	Miscellaneous Exp (IC00)	0	27	35
36	Depr - Equipment (IC00)	0	27	36
37	Interest Expense - Interco (IC00)	42,455	32	37
38	FAS 121 Charge	0	21	38
39	Interest Expense - Net Assets	0	32	39
40	Pto Accrual Adjustment	0	22	40
41	Pto Accrual Adjustment to Actual	2,224	22	41
42	Health Insurance	(20,342)	22	42
43	Worker's Compensation Audit Adjustment	0	22	43
44	Worker's Compensation Adjustment	(4,004)	22	44
45	Professional & General Liability Adjustment	(65,010)	26	45
46	Property Insurance Adjustment	626	26	46
47	Auto Insurance Adjustment	(996)	26	47
48	Interest Expense	(24,815)	32	48
49	**Total**	(146,850)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	2,834	0	0	0	0	0	0	0	0	0	0	2,834	1
2	Food Purchase	(70)	0	0	0	0	0	0	0	0	0	0	(70)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,094	0	0	0	0	0	0	0	0	0	1,094	5
6	Maintenance	0	374	(5,472)	0	0	0	0	0	0	0	0	(5,098)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	2,764	1,468	(5,472)	0	0	0	0	0	0	0	0	(1,240)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	21	0	0	0	0	0	0	0	0	0	21	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	21	0	0	0	0	0	0	0	0	0	21	16
	C. General Administration													
17	Administrative	(77,478)	4,443	0	0	0	0	0	0	0	0	0	(73,035)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,056	0	0	0	0	0	0	0	0	0	7,056	19
20	Fees, Subscriptions & Promotions	14,581	408	0	0	0	0	0	0	0	0	0	14,989	20
21	Clerical & General Office Expenses	313	84,177	0	0	0	0	0	0	0	0	0	84,490	21
22	Employee Benefits & Payroll Taxes	(22,121)	10,483	0	0	0	0	0	0	0	0	0	(11,638)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,816	0	0	0	0	0	0	0	0	0	6,816	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(65,380)	2,424	0	0	0	0	0	0	0	0	0	(62,956)	26
27	Other (specify):*	8,067	0	0	0	0	0	0	0	0	0	0	8,067	27
28	**TOTAL General Administration**	(142,018)	115,807	0	0	0	0	0	0	0	0	0	(26,211)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(139,254)	117,296	(5,472)	0	0	0	0	0	0	0	0	(27,430)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **SunBridge Care & Rehab - Edwardsville** **# 0042689** **Report Period Beginning:** **01/01/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(108)	0	0	0	0	0	0	0	0	0	0	(108)	30
31	Amortization of Pre-Op. & Org.	0	10,383	0	0	0	0	0	0	0	0	0	10,383	31
32	Interest	17,355	0	11,265	0	0	0	0	0	0	0	0	28,620	32
33	Real Estate Taxes	7,336	0	0	0	0	0	0	0	0	0	0	7,336	33
34	Rent-Facility & Grounds	0	0	2,651	0	0	0	0	0	0	0	0	2,651	34
35	Rent-Equipment & Vehicles	0	0	5,871	0	0	0	0	0	0	0	0	5,871	35
36	Other (specify):*	0	11,335	913	0	0	0	0	0	0	0	0	12,248	36
37	**TOTAL Ownership**	24,583	21,718	20,700	0	0	0	0	0	0	0	0	67,001	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(114,672)	139,014	15,228	0	0	0	0	0	0	0	0	39,570	45

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SunBridge Healthcare Corp.	100%	Please see attached	Please see attached	See 6A	See 6A	See 6A

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$	SunBridge Healthcare Corporation	100.00%	$ 4,443	$ 4,443	1
2	V	5	Heat and Other Utilities		SunBridge Healthcare Corporation	100.00%	1,094	1,094	2
3	V	6	Maintenance		SunBridge Healthcare Corporation	100.00%	374	374	3
4	V	14	Program Transportation		SunBridge Healthcare Corporation	100.00%	21	21	4
5	V	19	Legal & Accounting		SunBridge Healthcare Corporation	100.00%	7,056	7,056	5
6	V	20	Dues and Subscriptions		SunBridge Healthcare Corporation	100.00%	408	408	6
7	V	21	General Office Expenses		SunBridge Healthcare Corporation	100.00%	84,177	84,177	7
8	V	22	Employee Benefits		SunBridge Healthcare Corporation	100.00%	10,483	10,483	8
9	V	24	Travel		SunBridge Healthcare Corporation	100.00%	6,816	6,816	9
10	V	26	Insurance		SunBridge Healthcare Corporation	100.00%	2,424	2,424	10
11	V	36	Depreciation		SunBridge Healthcare Corporation	100.00%	11,335	11,335	11
12	V	31	Amortization		SunBridge Healthcare Corporation	100.00%	10,383	10,383	12
13	V								13
14	Total			$			$ 139,014	$ * 139,014	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	SunBridge Healthcare Corporation	100.00%	$ 11,265	$ 11,265	15
16	V	36	Property Taxes		SunBridge Healthcare Corporation	100.00%	913	913	16
17	V	34	Facility Lease		SunBridge Healthcare Corporation	100.00%	2,651	2,651	17
18	V	35	Equipment Lease		SunBridge Healthcare Corporation	100.00%	5,871	5,871	18
19	V	10	Pharmacy Expense	126,292	SunScript Pharmacy Corporation	100.00%	126,292		19
20	V	10a	Physical,Speech,Occupational Ther	292,896	SunDance Rehabilitation Corporation	100.00%	292,896		20
21	V	10a	Respiratory Therapy	4,041	SunCare Respiratory	100.00%	4,041		21
22	V	10	Medical Supplies & Equipment Rental	2,640	SunChoice Medical Supply	100.00%	2,640		22
23	V	6	Software	7,200	Shared Healthcare System, Inc.	70.40%	1,728	(5,472)	23
24	V	10	Medical Supplies & Equipment Rental	59,180	Medline Industries, Inc.	100.00%	59,180		24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 492,249			$ 507,477	$ * 15,228	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	1,557,938,434	311	$ 1,692,927	$ 1,692,927	4,063,069	$ 4,415	1
2	5	Heat and Other Utilities	Accumulated Cost	1,557,938,434	311	387,282		4,063,069	1,010	2
3	6	Maintenance	Accumulated Cost	1,557,938,434	311	133,507		4,063,069	348	3
4	14	Program Transportation	Accumulated Cost	1,557,938,434	311	8,045		4,063,069	21	4
5	19	Legal & Accounting	Accumulated Cost	1,557,938,434	311	2,667,822		4,063,069	6,958	5
6	20	Dues and Subscriptions	Accumulated Cost	1,557,938,434	311	94,945		4,063,069	248	6
7	21	General Office Expenses	Accumulated Cost	1,557,938,434	311	25,594,615	19,078,284	4,063,069	66,750	7
8	22	Employee Benefits	Accumulated Cost	1,557,938,434	311	2,972,051		4,063,069	7,751	8
9	24	Travel	Accumulated Cost	1,557,938,434	311	1,503,862		4,063,069	3,922	9
10	26	Insurance	Accumulated Cost	1,557,938,434	311	923,577		4,063,069	2,409	10
11	36	Depreciation	Accumulated Cost	1,557,938,434	311	4,318,111		4,063,069	11,262	11
12	31	Amortization	Accumulated Cost	1,557,938,434	311	3,955,690		4,063,069	10,316	12
13	32	Interest	Accumulated Cost	1,557,938,434	311	4,291,770		4,063,069	11,193	13
14	36	Property Taxes	Accumulated Cost	1,557,938,434	311	346,868		4,063,069	905	14
15	34	Facility Lease	Accumulated Cost	1,557,938,434	311	588,958		4,063,069	1,536	15
16	35	Equipment Lease	Accumulated Cost	1,557,938,434	311	2,017,657		4,063,069	5,262	16
17										17
18										18
19		Total from attached Page 8a	Accumulated Cost	5,713					0	19
20		Total from attached Page 8b	Accumulated Cost	19,695					0	20
21										21
22			Total Units =							22
23			1,557,938,434							23
24										24
25	TOTALS					$ 51,497,687	$ 20,771,211		$ 134,306	25

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	300,771,607	75	$ 464	$ 464	4,063,069	$ 6	1
2	5	Heat and Other Utilities	Accumulated Cost	300,771,607	75	104		4,063,069	1	2
3	6	Maintenance	Accumulated Cost	300,771,607	75	535		4,063,069	7	3
4	14	Program Transportation	Accumulated Cost	300,771,607	75	2		4,063,069		4
5	19	Legal & Accounting	Accumulated Cost	300,771,607	75	560		4,063,069	8	5
6	20	Dues and Subscriptions	Accumulated Cost	300,771,607	75	170		4,063,069	2	6
7	21	General Office Expenses	Accumulated Cost	300,771,607	75	276,688	172,279	4,063,069	3,738	7
8	22	Employee Benefits	Accumulated Cost	300,771,607	75	50,438		4,063,069	681	8
9	24	Travel	Accumulated Cost	300,771,607	75	55,683		4,063,069	752	9
10	26	Insurance	Accumulated Cost	300,771,607	75	253		4,063,069	3	10
11	36	Depreciation	Accumulated Cost	300,771,607	75	1,183		4,063,069	16	11
12	31	Amortization	Accumulated Cost	300,771,607	75	1,084		4,063,069	15	12
13	32	Interest	Accumulated Cost	300,771,607	75	1,176		4,063,069	16	13
14	36	Property Taxes	Accumulated Cost	300,771,607	75	247		4,063,069	3	14
15	34	Facility Lease	Accumulated Cost	300,771,607	75	26,276		4,063,069	355	15
16	35	Equipment Lease	Accumulated Cost	300,771,607	75	8,127		4,063,069	110	16
17										17
18										18
19										19
20										20
21			Total Units =							21
22			300,771,607							22
23										23
24										24
25	TOTALS					$ 422,990	$ 172,743		$ 5,713	25

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	154,186,355	41	$ 844	$ 844	4,063,069	$ 22	1
2	5	Heat and Other Utilities	Accumulated Cost	154,186,355	41	3,158		4,063,069	83	2
3	6	Maintenance	Accumulated Cost	154,186,355	41	735		4,063,069	19	3
4	14	Program Transportation	Accumulated Cost	154,186,355	41	3		4,063,069		4
5	19	Legal & Accounting	Accumulated Cost	154,186,355	41	3,434		4,063,069	90	5
6	20	Dues and Subscriptions	Accumulated Cost	154,186,355	41	6,010		4,063,069	158	6
7	21	General Office Expenses	Accumulated Cost	154,186,355	41	519,488	401,422	4,063,069	13,689	7
8	22	Employee Benefits	Accumulated Cost	154,186,355	41	77,848		4,063,069	2,051	8
9	24	Travel	Accumulated Cost	154,186,355	41	81,286		4,063,069	2,142	9
10	26	Insurance	Accumulated Cost	154,186,355	41	461		4,063,069	12	10
11	36	Depreciation	Accumulated Cost	154,186,355	41	2,154		4,063,069	57	11
12	31	Amortization	Accumulated Cost	154,186,355	41	1,973		4,063,069	52	12
13	32	Interest	Accumulated Cost	154,186,355	41	2,140		4,063,069	56	13
14	36	Property Taxes	Accumulated Cost	154,186,355	41	173		4,063,069	5	14
15	34	Facility Lease	Accumulated Cost	154,186,355	41	28,835		4,063,069	760	15
16	35	Equipment Lease	Accumulated Cost	154,186,355	41	18,944		4,063,069	499	16
17										17
18										18
19										19
20			Total Units =							20
21			154,186,355							21
22										22
23										23
24										24
25	TOTALS					$ 747,486	$ 402,266		$ 19,695	25

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Interest from Page 8-8b										11,265	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 11,265	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 11,265	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	49,804	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	57,140	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,336	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	59,561	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	66,897	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	75,096	8
1997	58,639	9
1998	60,899	10
1999	56,172	11
2000	57,140	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SunBridge Care & Rehab - Edwardsville COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0042689

CONTACT PERSON REGARDING THIS REPORT Sylvia Moreno

TELEPHONE (505) 468-4984 FAX #: (505)468-4969

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-1-16-07-00-000-019.003	401 St. Mary's Dr.	$ 57,140.16	$ 57,140.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 57,140.16	$ 57,140.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	A/C UNITS (30/DIRECT SUPPLY			1997	1,990						9
10	A/C HEAT (7)/DIRECT SUPPLY			1998	4,892						10
11	A/C HEATER/DIRECT SUPPLY			1998	4,067						11
12	COOLING UNIT/AMK HEATING			1998	3,492						12
13	EXTERIOR SIGN-LOGO/ACME WILEY			1998	6,243	13,249	5-15	13,249		33,244	13
14	EXTERIOR PLUMBING/ST LOUIS			1998	7,892						14
15	HOT WATER HEATER/ALL METRO			1998	4,368						15
16	Water heater			1999	4,368						16
17	FIRE ALARM/SYSTEM UPGRADE			1999	1,161						17
18	DOOR-LABOR/GRANITE INC.			1999	2,590						18
19	DOOR MONITOR SYSTEM			1999	2,646						19
20	ELECTRICAL WIRING FOR WASHER/D			1999	2,675						20
21	PAINT HALLWAY DOORS/GEG MARLEY			1999	7,200						21
22	PAINT HALLS LR DR			1999	7,900						22
23	Rub Rails			1999	2,230						23
24	DUCT/HEATER/FAN			1999	1,791						24
25	REPLACE ROOF			1999	5,556						25
26	Comp/Phone Cabling Upgrade			1999	3,460						26
27	Water Heater (10YR)			2000	3,980						27
28	2 - 5TON A/C UNITS			2000	8,700						28
29	BRICKFLOOR			2000	4,925						29
30	ROOFTOP AC UNIT			2000	4,650						30
31	HEAT/COOL UNIT			2000	1,997						31
32	SHOWER UPGRADE			2000	1,439						32
33	2 HEAT COOL UNITS			2000	1,348						33
34	119 GAL WATER HEATERS			2000	12,790						34
35	7 1/2 RON AC/HEAT UNIT			2001	5,075						35
36	7 1/2 TON AC/HEAT UNIT			2001	5,075						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	4 ZONELINE HEAT/AC UNITS	2001	$ 2,349	$		$	$	$	37
38	2 HEAT/COOL UNITS-ZONELINE	2001	1,205						38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 128,053	$ 13,249		$ 13,249	$	$ 33,244	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 102,930	$ 14,698	$ 14,698	$		$ 52,963	71
72	Current Year Purchases	15,603	1,730	1,730			1,730	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 118,533	$ 16,428	$ 16,428	$		$ 54,693	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 246,586	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,677	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 29,677	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 87,937	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Omega Healthcare Investors, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1978	120	6/1/97	$ 226,172	14	14	3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 226,172 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 6/1/1997
Ending 5/30/2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$ 238,612
13.	12/31/2003	$ 251,736
14.	12/31/2004	$ 258,659

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 26,542 Description: Please See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transport	1997Ford Club Wagon	$ 282.62	$ 3,391	17
18					18
19					19
20					20
21	TOTAL		$ 282.62	$ 3,391	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Line 10a Col 3	mods	$	4,788	$ 64,641	$ 13,835	4,788	$ 78,476	1
2	Licensed Speech and Language Development Therapist	Line 10a Col 3	hrs mods		2,916	39,360	5,540	2,916	44,900	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a Col 3	mods		11,214	151,393	18,127	11,214	169,520	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 10 Col 2	# of prescrpts			34,968	76,767		111,735	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): IV Therapy & LALT	Line 10a Col 3				26,320	39,735		66,055	13
14	TOTAL			$	18,918	$ 316,682	$ 154,004	18,918	$ 470,686	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 341,921	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(86,650)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	602		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Please See Attached			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 255,873	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	128,053		15
16	Equipment, at Historical Cost	118,533		16
17	Accumulated Depreciation (book methods)	(87,937)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	334,081		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(61,957)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Please See Attached	67,099		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 497,872	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 753,745	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (67,204)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(128,388)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(76,057)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(59,997)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Please See Attached	(98,341)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (429,987)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		(1,375,611)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,375,611)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (1,805,598)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,051,853	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (753,745)	$	48

***(See instructions.)**

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,364,687	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,364,687	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	11,929	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Intercompany Eliminations**	(324,763)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (312,834)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,051,853	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,731,247	1
2	Discounts and Allowances for all Levels	133,219	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,864,466	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	158,115	6
7	Oxygen	31,649	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 189,764	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,751	13
14	Non-Patient Meals	471	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	24,798	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,741	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,278	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 51,039	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	286	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 286	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Please See Attached	4,466	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,466	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,110,021	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	697,337	31
32	Health Care	1,940,696	32
33	General Administration	1,012,288	33
	B. Capital Expense		
34	Ownership	361,580	34
	C. Ancillary Expense		
35	Special Cost Centers	86,191	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,098,092	40
41	**Income before Income Taxes (line 30 minus line 40)****	11,929	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 11,929	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,335	3,044	$ 66,250	$ 21.76	1
2	Assistant Director of Nursing	109	181	2,825	15.62	2
3	Registered Nurses	10,364	8,650	171,767	19.86	3
4	Licensed Practical Nurses	26,300	26,230	408,880	15.59	4
5	Nurse Aides & Orderlies	64,417	64,255	590,213	9.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,149	2,057	21,190	10.30	9
10	Activity Assistants	1,739	1,717	11,249	6.55	10
11	Social Service Workers	4,015	3,857	42,473	11.01	11
12	Dietician	2,089	2,131	27,955	13.12	12
13	Food Service Supervisor	260	287	6,608	23.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,515	15,797	111,283	7.04	15
16	Dishwashers					16
17	Maintenance Workers	2,796	2,664	24,632	9.25	17
18	Housekeepers					18
19	Laundry			474		19
20	Administrator	1,966	1,831	60,414	32.99	20
21	Assistant Administrator	370	388	5,038	12.98	21
22	Other Administrative	4,508	4,109	60,539	14.73	22
23	Office Manager	245	286	3,408	11.90	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,610	6,071	73,642	12.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,787	143,556	$ 1,688,841 *	$ 11.76	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$	1.3	35
36	Medical Director	$1300/mo	15,600	9.1	36
37	Medical Records Consultant	$270/Bi mo	3,230	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	17	6,960	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	111	4,755	10.3	45
46	Other(specify) A&G Consulting Fees	7	671	19.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	135	$ 31,216		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terri Rumler	Administrator	0	$ 60,493
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,493

B. Administrative - Other

Description	Amount
Management Fees	$ 77,478
Regional Allocation	97,084
TOTAL (agree to Schedule V, line 17, col. 3)	$ 174,562
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sentry Plus	SB Name Badges	$ 56
Esparza King	Design of Strategic Plan	38
Eproperty Tax	Real & Personal Property Info	100
Rick Johnson & CO	Advertising	88
Legal Fees	Collections\Legal Fees	30,000
Maun Lemke Inc.	Consultant Fees	671
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 30,954

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Employee Benefits	10,483
TOTAL (agree to Schedule V, line 22, col.8)	$ 10,483

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,100
Advertising: Employee Recruitment	15,820
Health Care Worker Background Check	
(Indicate # of checks performed)	
Pen. & late Fees\Chamber of Commerce	(17,165)
IHCA\Bank Charges\Comm R.\Hurtieau	6,996
H.O. Dues & Subs\Reiman Publications	470
New Democrat\Belleville\Corp Health	255
Reminisce\Birds Bloom\Heaton\Terri Rumle	287
Lessb Pen. & late Fees\Chamber of Comm	14,581
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,344

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,042
In-State Travel	11,313
Home Office Travel	6,816
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,171

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville # 0042689 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SunBridge Care & Rehab - Edwardsville **#** 0042689 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Assoc. $6639.97**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,604** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,720**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Arthur Andersen & Co** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Financial Statements are consolidated**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

03.01.01.	145846	40880	0	186726
03.01.02.	14695	0	0	14695
03.01.03.	465	0	0	465
03.01.05.	0	0	0	0
03.02.02.	147699	0	2764	150463
03.03.01.	0	0	0	0
03.03.02.	487	0	0	487
03.03.03.	237418	0	0	237418
03.04.01.	474	-233	0	241
03.04.02.	9768	0	0	9768
03.04.03.	64735	0	0	64735
03.06.01.	24632	6916	0	31549
03.06.02.	5135	0	0	5135
03.06.03.	45983	0	-1841	44143
03.07.03.	0	0	0	0
03.09.01.	0	0	0	0
03.09.03.	15600	0	0	15600
03.10.01.	1270355	355952	0	1626307
03.10.02.	159684	0	0	159684
03.10.03.	51904	0	0	51904
03.10.05.	0	0	0	0
03.10.a.01	0	0	0	0
03.10.a.02	77256	0	0	77256
03.10.a.03	281714	0	0	281714
03.11.01.	32439	8989	0	41428
03.11.02.	4516	0	0	4516
03.11.03.	0	0	0	0
03.12.01.	42473	11926	0	54399
03.12.02.	0	0	0	0
03.12.03.	4755	0	0	4755
03.13.03.	0	0	0	0
03.14.03.	0	0	0	0
03.15.03.	0	0	2102	2102
03.17.01.	60493	16986	0	77479
03.17.03.	174562	-662	-80277	93623
03.18.03.	0	0	0	0
03.19.03.	30954	0	0	30954
03.20.03.	7355	0	17165	24520
03.21.01.	112129	32785	0	144914
03.21.02.	13164	0	0	13164
03.21.03.	44056	0	51	44106
03.22.03.	496321	-474200	-22121	0
03.23.03.	575	0	0	575
03.24.03.	12355	0	0	12355
03.26.03.	68606	0	-65380	3226
03.27.03.	-8282	0	8282	0
04.30.03.	29785	0	-108	29677
04.31.03.	33261	0	0	33261
04.32.03.	-17355	0	17355	0
04.33.03.	59561	0	7336	66897
04.34.03.	226172	0	0	226172
04.34.05.	0	0	0	0
04.35.03.	29934	0	0	29934
04.35.05.	0	661	0	662
04.36.03.	222	0	0	222
04.38.03.	0	0	0	0
04.39.03.	0	0	0	0
04.40.02.	0	0	0	0
04.40.03.	0	0	0	0
04.41.03.	0	0	0	0
04.42.03.	74720	0	0	74720
04.43.02.	2763	0	0	2763
04.43.03.	8708	0	0	8708
17.01.	341921	0	0	341921
17.03.	-86650	0	0	-86650
17.04.	0	0	0	0
17.06.	602	0	0	602
17.07.	0	0	0	0
17.13.	0	0	0	0
17.14.	0	0	0	0
17.15.	130974	0	-2921	128053
17.16.	118533	0	0	118533
17.17.	-87518	0	-419	-87937
17.19.	334081	0	0	334081
17.20.	-61957	0	0	-61957
17.22.	0	0	0	0
17.23.	67099	0	0	67099
17.26.	-67204	0	0	-67204
17.30.	-128388	0	0	-128388
17.31.	-76057	0	0	-76057
17.32.	-59997	0	0	-59997
17.36.	-98341	0	0	-98341
17.39.	0	0	0	0
17.43.	-1375611	0	0	-1375611
17.44.	0	0	0	0
17.47.	1060442	0	0	1060442
19.01.	-3731247	0	0	-3731247
19.02.	-133219	0	0	-133219
19.06.	-158115	0	0	-158115
19.07.	-31649	0	0	-31649
19.13.	-1751	0	0	-1751
19.14.	-471	0	0	-471
19.17.	-24798	0	0	-24798
19.19.	-15741	0	0	-15741
19.20.	0	0	0	0
19.21.	-8278	0	0	-8278
19.22.	0	0	0	0
19.25.	-286	0	0	-286
19.28.	-4466	0	0	-4466
19.28.a.	0	0	0	0